MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14672 **CERTIFICATE OF DEATH** 14638

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BERLIN
d. STREET ADDRESS: 1 R.F.D
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JAMES Middle DANIEL Last BETHARDS

4. DATE OF DEATH: Month DEC Day 21 Year 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: MAY 10, 1882

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM

11. BIRTHPLACE (County & State, or foreign country): BERLIN MD

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: LITTLETON BETHARDS

14. MOTHER'S MAIDEN NAME: CORNELIA DENNIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MR. RAYMOND BETHARDS BERLIN MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 442X Congestive Heart Failure
DUE TO (b): Chronic Myocarditis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hypertension

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-5, 1959 to 12-21, 1961 that (I) (we) last saw the deceased alive on 12-15 1961, and that death occured at 10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. PHYSICIAN'S NAME, Type: CLIFFORD E. SCHOTT M.D.

22d. ADDRESS: Berlin Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12/23/61

23c. NAME OF CEMETERY OR ~~CREMATORY~~: RIVERSIDE

23d. LOCATION (City, town or county) (State): BERLIN MD

24 FUNERAL DIRECTOR'S SIGNATURE: Anne A Bunting

ADDRESS: Berlin Md

25a. REC'D BY REGISTRAR DATE: DEC 27 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, insert by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14673 **CERTIFICATE OF DEATH** 14639

This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Worcester — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Snow Hill
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): R.F.D. 2 Snow Hill
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Worcester
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Snow Hill
   d. STREET ADDRESS: R.F.D. 2 Snow Hill
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]
3. NAME OF DECEASED (Type or print): First: Lucile; Middle: ; Last: Clark
4. DATE OF DEATH: Month: December; Day: 4; Year: 19 6I
5. SEX: F.
6. COLOR OR RACE: C.
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: about
9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): ~~Maryland~~ Florida
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown ~~Mable allen R.F.D. 2 Snow Hill~~
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO.:
17. INFORMANT / Address: Mable allen R.F.D 2 Snow Hill Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of breast with widespread metastases — INTERVAL BETWEEN ONSET AND DEATH: 1yr.?
170X
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [·]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-27, 1961, to 12-4, 1961, that (I) (we) last saw the deceased alive on 12/1 1961, and that death occured at 11 P.M., from the causes and on the date stated abov[e]

22a. SIGNATURE: Ivory U. Sully, Jr. M.D.
ATTENDING PHYS. [✓] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. 12/6/6[1]
22c. PHYSICIAN'S NAME (Type): IVORY U. Sully. Jr. MD
22d. ADDRESS: Berlin. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: I2/9/ I96I
23c. NAME OF CEMETERY OR CREMATORY: Baptis
23d. LOCATION (City, town or county): Snow Hill (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Clifton F. Stewart ADDRESS: Salis. Md
25a. REC'D BY REGISTRAR DATE: DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kra[illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14674 Reg. Dist. No. 14640

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton
c. LENGTH OF STAY IN 1b 10 Yrs Plus
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) P. L. Poultry Plant

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goodlestown
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Roger Middle William Last Harmon
4. DATE OF DEATH Month December Day 21 Year 19 61

5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Feb 12-1930
9. AGE (In years last birthday) 31 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Chicken Factory
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Roger Harmon
14. MOTHER'S MAIDEN NAME Helen Blake

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War 2
16. SOCIAL SECURITY NO. 215-26-5391
17. INFORMANT Mrs Gladys Harmon Address Girdletree Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 9811
DUE TO (b) Homicide by Firearm — 32 Automatic
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in head
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Stockton P.L. Poultry Plt.
20f. (City or town) Stockton (County) Worcester (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE N. E. Sartorius Sr M.D.
EXAMINER'S NAME (Type) N. E. Sartorius
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 12/23/61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12-26-61
22c. NAME OF CEMETERY OR CREMATORY Cool Spring Cemetery
22d. LOCATION (City, town, or county) Girdletree (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Samuel Lowe
ADDRESS Mila Church 20,1
24a. REC'D BY REGISTRAR DATE DEC 29 '61
24b. REGISTRAR'S SIGNATURE Arthur L. Pruitt

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14675 14641

1. **PLACE OF DEATH**
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bishop
c. LENGTH OF STAY IN 1b: 30 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): ----

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bishops
d. STREET ADDRESS: -----
a. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Minnie — Middle: L. — Last: Hignutt

4. **DATE OF DEATH**: Month: December — Day: 18 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: May 2, 1874

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Kendal S. Powell

14. MOTHER'S MAIDEN NAME: Fannie Patey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: -----

17. INFORMANT: Grace Hudson — Address: Bishops, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cerebral vascular thrombosis
332 X
DUE TO
(b): generalized arteriosclerotic disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from September, 1961, to December, 1961 that (I) (we) last saw the deceased alive on December 6 1961, and that death occured at 5am, from the causes and on the date stated above.

22a. SIGNATURE: Frank E. Gantz Jr. M.D.

22b. PHYSICIAN'S NAME (Type): Frank E. Gantz Jr. M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. 12-18-6

22d. ADDRESS: 5 Bay St. Berlin, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-20-61

23c. NAME OF CEMETERY OR CREMATORY: Odd Fellows

23d. LOCATION (City, town or county) (State): Bishopville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley — ADDRESS: Selbyville, Del.

25a. REC'D BY REGISTRAR DATE: DEC 22 '61

25b. REGISTRAR'S SIGNATURE: Lindsay S. Evans

1 M X I

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained by the funeral director for his files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14676 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14642

1. **PLACE OF DEATH**
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural-Pocomoke City
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): R.F.D. 2

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural-Pocomoke City
d. STREET ADDRESS: 1 R.F.D. 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First ELIZABETH — Middle VIRGINIA — Last HILL
4. **DATE OF DEATH**: Month December — Day 19 — Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: July 4, 1875
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George R. Tawes
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Ryland M. Hill, Address: Virginia Road Pocomoke City, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary disease — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: N. E. Sartorius Sr. M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SI
EXAMINER'S NAME (Type): N. E. SARTORIUS, SR.
Address (Street, city, town, or county): Pocomoke City,

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-21-61
22c. NAME OF CEMETERY: Parksley Cemetery
22d. LOCATION (City, town, or country) (State): Parksley, Virginia

23. FUNERAL DIRECTOR: Henry H. Watson
ADDRESS: Pocomoke City, Md.
24a. REC'D BY REGISTRAR DATE: DEC 26 '61
24b. REGISTRAR'S SIGNATURE: Clinton S. Evans

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14677 14643

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BERLIN (RURAL)
c. LENGTH OF STAY IN 1b: WKS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Rt # 1 Box 38

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BERLIN (RURAL)
d. STREET ADDRESS: Rt # 1 Box 38
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Henry — Middle: Harrison — Last: Lee, III

4. DATE OF DEATH: Month: December — Day: 17, — Year: 1961

5. SEX: M

6. COLOR OR RACE: AA

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: NOV 3-1961

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 1 Days: 14
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HENRY LEE JR

14. MOTHER'S MAIDEN NAME: BERNADINE SHORT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give wer or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT Address: HENRY LEE JR, BERLIN, MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary edema
DUE TO (b): acute bronchopneumonia
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 day

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert C. LaMar M.D.

EXAMINER'S NAME (Type): Robert C. LaMar, M. D., Maryland

Address (Street, city, town, or county): Snow Hill

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12-18-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 12-18-61

22c. NAME OF CEMETERY OR CREMATORY: NEW BETHEL CEM.

22d. LOCATION (City, town, or country) (State): BERLIN, Md.

23. FUNERAL DIRECTOR ADDRESS: Thornton B. Jolley, Salisbury Md

24a. REC'D BY REGISTRAR DATE: DEC 27 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

8

2082235XV8

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14678

CERTIFICATE OF DEATH

14644

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Worcester — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Whaleyville
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): XX

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   e. STATE: Maryland — b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Whaleyville
   d. STREET ADDRESS: RFD
   a. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: HORACE — Middle: W. — Last: LITTLETON

4. **DATE OF DEATH**: Month: Dec. — Day: 10, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: April 3, 1886

9. AGE (In years last birthday): 75 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John W. Littleton

14. MOTHER'S MAIDEN NAME: Elen Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): XX
    (If yes give war or dates of service): XX

16. SOCIAL SECURITY NO.: 218-34-3108

17. INFORMANT: Mrs. Ella Lewis Bishop, Md. — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Prostate Gland & Metastasis.
177X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 1 year.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): —

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

20f. (City or town): — (County): — (State): —

21. **I certify** that (I) (this hospital) attended the deceased from 8-24, 1961, to 12-10, 1961, that (I) (we) last saw the deceased alive on 12-10 1961, and that death occured at 2:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Frank Lewis M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

27. DATE SIGNED: 12-11-61

22c. PHYSICIAN'S NAME (Type): Frank R. Lewis M.D.

22d. ADDRESS: Willards, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/13/61

23c. NAME OF CEMETERY OR CREMATORY: Dale

23d. LOCATION (City, town or county) (State): Whaleyville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley — ADDRESS: Selbyville, Del.

25a. REC'D BY REGISTRAR DATE: DEC 13 '61

25b. REGISTRAR'S SIGNATURE: Clinton S. Mears

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14679 (left) 14678 (right)

FOR STATE HEALTH DEPT. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural-Pocomoke City
c. LENGTH OF STAY IN 1b: about 5 weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Hillman Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admissio
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 42 Pocomoke City
d. STREET ADDRESS: 1 Clarke Avenue Ext.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARLTON — Middle WILLIAM — Last MEARS

4. DATE OF DEATH: Month about December — Day 15 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 15,1926

9. AGE (In years last birthday): 35 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Day Labor

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles T. Mears

14. MOTHER'S MAIDEN NAME: Mae Ann Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give wer or dates of service): Korean

16. SOCIAL SECURITY NO.: ---

17. INFORMANT — Address: Charles T. Mears, Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bullet Wound Thru Heart & Left Lung
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: none

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): alcoholism,

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Robert C. La Mar M.D.

EXAMINER'S NAME (Type): Robert C. La Mar, M. D.
Robert C. La Mar

Address (Street, city, town, or county): Snow Hill, Md.

DATE SIGNED: 1-22-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-23-62

22c. NAME OF CEMETERY: Wattsville Methodist

22d. LOCATION (City, town, or country) (State): Wattsville, Virginia

23. FUNERAL DIRECTOR: Henry F. Walker

ADDRESS: Pocomoke City, Md.

24a. REC'D BY REGISTRAR — DATE: JAN 24 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

FOR STATE HEALTH DEPT.

M

I

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14680 — 14645

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City, Md.
d. STREET ADDRESS: 1302 Dorchester St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Webster — Middle: Byron — Last: Metz

4. DATE OF DEATH: Month: 12 — Day: 10 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/22/1874

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor at Saw Mill

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm Metz

14. MOTHER'S MAIDEN NAME: Mary Sheets

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Vernon R. Metz (Son) Box #85 Bridgeville, Del. Mrs. Webster Metz - Pocomoke, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: N. E. Sartorius Sr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12/[illegible]/61

EXAMINER'S NAME (Type): N. E. Sartorius

Address (Street, city, town, or county): 226 Market St Pocomoke, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-13-61

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town or country): Salisbury Wicomico (State): Md.

23. FUNERAL DIRECTOR: Holloway & Co. — ADDRESS: Salisbury, Md

24a. REC'D BY REGISTRAR DATE: DEC 15 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14681 14646

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Berlin Md
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural, Berlin
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Howard; Middle:; Last: Purnell

4. DATE OF DEATH: Month: Dec; Day: 1; Year: 1961

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: July 1 1882
9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (County & State, or foreign country): Snow Hill Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dan Jones
14. MOTHER'S MAIDEN NAME: Mary Hammond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 214-32-6367R
17. INFORMANT Address: Hazel Lockwood, R.F.D. #3 Berlin, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial
443 X
DUE TO (b): Chronic Myocardial
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Hypertension

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-15-61 19..., to 12-1-61 19..., that (I) (we) last saw the deceased alive on 11-25-61 19..., and that death occured at 1:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22. [redacted] SIGNED
22c. PHYSICIAN'S NAME (Type): CLIFFORD E. SCHOTT MD
22d. ADDRESS: BERLIN MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-4-61
23c. NAME OF CEMETERY OR CREMATORY: Mt. Wesley Cemetery
23d. LOCATION (City, town or county) (State): Snow Hill Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Forman F. Harris, Snow Hill, Md.
25a. REC'D BY REGISTRAR DATE: DEC 5 '61
25b. REGISTRAR'S SIGNATURE: Clifton L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [redacted]4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [redacted] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the

15M VR

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14683 14647

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): OCEAN CITY
c. LENGTH OF STAY IN 1b: 41 YRS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residance before admission)
a. STATE: MARYLAND b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X OCEAN CITY
d. STREET ADDRESS: 15th ST
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle HAZZARD Last QUILLIN

4. DATE OF DEATH: Month DEC Day 31 Year 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: DEC. 1, 1920

9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONTRACTUR

10b. KIND OF BUSINESS OR INDUSTRY: CONCRETE

11. BIRTHPLACE (County & State, or foreign country): OCEAN CITY MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ROBERT F. QUILLIN

14. MOTHER'S MAIDEN NAME: ELLA B. TAYLOR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give wer or detas of service): WORLD WAR II

16. SOCIAL SECURITY NO.: 219-03-0003

17. INFORMANT Address: MRS. R. H. QUILLEN, OCEAN CITY MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion gate — INTERVAL BETWEEN ONSET AND DEATH: INSTANT
DUE TO (b): Arterio Sclerotic CVD — 11 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JUNE 1950 to Dec 31 61, that (I) (~~was~~) last saw the deceased alive on Dec 29 61, and that death occured at 920A M, from the causes and on the date stated above.

22a. SIGNATURE: H. Townsend Jr M.D.

ATTENDING PHYS. X MED. DIRECTOR ☐ STAFF PHYS. ☐ Jan 1, 62 SIGNED

22c. PHYSICIAN'S NAME (Type): FRANCIS J. TOWNSEND JR

22d. ADDRESS: Ocean City, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/2/62

23c. NAME OF CEMETERY OR ~~CREMATORY~~: EVERGREEN

23d. LOCATION (City, town or county): BERLIN (State): MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — **ADDRESS**: Berlin Md

25a. REC'D BY REGISTRAR DATE JAN 4 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

15 (4) 9/60

TO HOSP[illegible]L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w[illegible]24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FU[illegible]AL DIRECTOR: After this certificate has been signed by the attending physician and completely fil[illegible]in by the funer[illegible]

VR A1
15M 9

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14682 Items 3,5 & 8 Film G305 1/22/62 iwk 14679

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Snow Hill Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Snow Hill
d. STREET ADDRESS: 1 Snow Hill
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Learh Middle W. Last Spencer

4. DATE OF DEATH: Month December Day 31 Year 1961

5. SEX: Female (Col.W-F.)

6. COLOR OR RACE: COL.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 16, 1906 (1906)

9. AGE (In years last birthday): 55 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Price

14. MOTHER'S MAIDEN NAME: Mary Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No.

16. SOCIAL SECURITY NO.:

17. INFORMANT: John Williams Address: Snow Hill

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 31, 1961, to Dec 31, 1961, that (I) (we) last saw the deceased alive on Dec 31 19 61, and that death occured at 3 P.M, from the causes and on the date stated above.

22a. SIGNATURE: David Rafat M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): DAVID RAFAT

22d. ADDRESS: Snow Hill Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: I✗ 5/ 1961

23c. NAME OF CEMETERY OR CREMATORY: Ebenizer

23d. LOCATION (City, town or county) (State): Snow Hill

24. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart — ADDRESS: Salisbury Md

25a. REC'D BY REGISTRAR DATE: JAN 17 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(4) /60